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ABSTRACT

This paper was designed to provide professional counselors with a comprehensive but concise method of accurately evaluting, interviewing, and planning for treatment of eating disorder clients. The paper is organized in five sections. The first section, Diagnosis, compares, contrasts, and offers clear explanations of the diagnostic criteria for anorexia and bulimia, as defined by the official manual of mental disorders of the American Psychiatric Association, the Diagnostic Statistical Manual of Mental Disorders. The second section, Selected Intake Interview Questions, assists the practitioner in: (1) examining the pattern of eating prior to and after the onset of the eating disorder; (2) assessing associated symptoms; (3) determining level of social activity and functioning; and (4) establishing medical/psychiatric history. Use of this section could improve diagnostic accuracy by assisting the counselor in ruling out symptoms of primary medical or psychiatric problems usually associated with eating disorders, and in making referrals. The third section, Philosophy Statement, stresses client involvement in an individualized treatment/recovery plan including appropriate therapy, behavioral contracting, nutritional education, self-help groups, cognitive restructuring, and medical back-up. The fourth and fifth sections concentrate on types of therapy and relapse. A discussion of related problems is included to aid in identifying significant problems co-existing with eating disorders. (Author/NB)

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DIAGNOSIS AND TREATMENT OF EATING DISORDERS

A Presentation to the Convention of the
American Association for Counseling and Development

April, 1985

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Abstract No. 1

"Anorexia Nervosa and Bulimia: Diagnosis and Treatment," presented at the 1985 AACD Convention provides professional counselors with a comprehensive but concise method of accurately evaluating, interviewing and planning for treatment of eating disorder clients.

The paper includes five sections. "Diagnosis" compares, contrasts, and offers clear explanations of the diagnostic criteria for Anorexia and Bulimia, as defined by the official manual of mental disorders of the American Psychiatric Association, the DSM III. "Selected Intake Interview Questions" assists the practitioner in 1) examining the pattern of eating prior to and after the onset of the eating disorder, 2) assessing associated symptoms, 3) determining level of social activity and functioning, and 4) establishing medical/psychiatric history. Use of this section could improve diagnostic accuracy by assisting the counselor in ruling out symptoms of primary medical or psychiatric problems usually associated with eating disorders, and in making referrals. The "Philosophy Statement" stresses client involvement in an individualized treatment/recovery plan including appropriate therapy, behavioral contracting, nutritional education, self-help groups, cognitive restructuring and medical back-up. "Types of Therapy," "Relapse" and treatment considerations are discussed in the fourth and fifth sections. The final section, "Related Problems" is helpful in identifying significant problems co-existing with eating disorders.

INTRODUCTION

Welcome to this session on the diagnosis and treatment of Anorexia Nervosa and Bulimia. How many of you are treating someone with an eating disorder? Hopefully there will be time for some sharing of experiences during our discussion period.

As has just been demonstrated, counselors are increasingly being confronted with eating disorders, regardless of the professional setting. What we are going to present to you reflects the research and work we have done on our own campus at Moorhead State. Hopefully you'll be able to take some of this home with you and put it to use in your own setting.

What we are going to do is show you how to make a diagnosis, go through a sample intake interview, and discuss treatment guidelines. Information of a more descriptive nature is readily accessible and we are providing you with a bibliography to enable you to do background reading on your own.

Section I
Diagnosis

We'll begin by examining the diagnostic criteria for Anorexia Nervosa. Anorexia is a serious illness of deliberate self starvation with profound psychiatric and physical components. The criteria as set out in DSM III which is a manual used for diagnosing mental disorders are as follows:

A. INTENSE FEAR OF BECOMING OBESE, WHICH DOES NOT DIMINISH AS WEIGHT LOSS PROGRESSES.

Most of us feel better with weight loss, but the anorectic does not.

B. DISTURBANCE OF BODY IMAGE, e.g., claiming to 'feel fat' even when emaciated or not fat.

An actual distortion of body image is present in varying degrees.

C. WEIGHT LOSS OF AT LEAST 25% OF ORIGINAL BODY WEIGHT OR, IF UNDER 18 YEARS OF AGE, WEIGHT LOSS FROM ORIGINAL BODY WEIGHT PLUS PROJECTED WEIGHT GAIN EXPECTED FROM GROWTH CHARTS MAY BE COMBINED TO MAKE THE 25%.

What this means is that if the individual is still in the growing years, we combine two things to come up the with 25%.

1. actual weight loss

2. weight we would have expected the individual to gain just in the natural process of growth and development.

While the DSM III uses 25% as a guideline, it is nearly uniformly accepted that 15% is a more realistic percentage. Waiting until the individual has lost 25% of their body weight can be quite dangerous. The means of achieving weight loss can be reducing food intake, extensive exercise and in many cases self induced vomiting and/or laxative abuse. Syrup of ipecac or diet pills may also be used to hasten weight loss.

D. REFUSAL TO MAINTAIN BODY WEIGHT OVER A MINIMAL NORMAL WEIGHT FOR AGE AND HEIGHT.

E. NO KNOWN PHYSICAL ILLNESS THAT WOULD ACCOUNT FOR THE WEIGHT LOSS.

1. A factor that needs to be taken into consideration when assessing the severity of the disorder is the rapidity of weight loss. Rapid weight loss is more dangerous than slow, steady weight loss.

F. Another important criteria which DSM III omitted, although it is mentioned elsewhere in the manual, is loss of the menstrual period. This is particularly significant since in approximately 1/3 of the cases, this is one of the first signs of the disorder, occurring before weight loss has become noticeable to others. This can be a real tip off to a potential problem.

At this point it might be helpful to you to have a glimpse from the inside looking out.

Diary Exerpts: This was taken from a diary of a student prior to treatment.

DAY	TIME & PLACE	TYPE OF FOOD	THOUGHTS
Mon.	8-9:00 AM (in class)	1 pack of gum	I need the gum to get me going. I wonder how many cavities I have. This is better than eating breakfast. I watched Jim eat & thought, "Wow! is he consuming mega calories. I'm glad I'm not."
Mon.	5:05 PM (campus store)	1 apple	I wonder if anyone saw me buy this. They are probably thinking, "Boy, is she fat. That's all she should eat!" I'll have to exercise for a while.
Tues.	10:00 (Student lounge)	2 packs of gum	I feel like a blimp today. I hope I won't eat a lot. I wish I wouldn't eat so much gum. I can't help myself. It seems like I don't have any will power.
Tues.	3:30 (at home)	1 apple, a few pieces of cauliflower, ½ piece of bread, ½ piece of cheese, 1 pack of gum	Drat, I blew it! Nothing more for me to eat. I'm mad at myself. I feel like I ate too much. I want to cry. I had a T.V. dinner in the oven but I took it out. Too many calories.
Tues.	evening		I did it again - I took ½ pack of laxatives. Why did I do that? I know it won't help because I need a whole box for it to do any good.
Wed.	throughout the day/home 6:30 (at home) 9:00	4 packs of gum 1 pear	I'm not going to eat very much today. I have to make up for yesterday!! Boy, am I hungry. This is the best pear I've ever had. I feel really scared. I thought about food all day today. I wish there was no such thing as food. I hate myself sometimes.

Hopefully this gives you some idea of the kind of thinking involved with this disorder and the desperation its victims sometimes feel. You will note, however, that this individual's fear and concern was not over her physical or mental well-being; it was over her preoccupation with food. If someone had confronted her with her inadequate intake of food, she would have more than likely denied that as a problem. This denial of the problem is one of the things that makes Anorexia Nervosa so difficult to treat.

Next the diagnostic criteria for bulimia will be discussed.

Bulimia has been called the sister ailment of Anorexia Nervosa. Victims of the two disorders share many of the same behaviors and concerns. They assess their worth by the numbers on the scale or by how far their stomachs protrude. Both groups tend to strive for perfection and success.

The exaggerated character of their perfectionistic striving is a challenging core issue to work with in treating either group. In contrast to Anorexia, Bulimia is characterized by compulsive binge eating usually accompanied by purging. The term Bulimia translated literally means "ox hunger." Food becomes an obsession and addiction--an escape from the pressures of life. Unlike victims of Anorexia, those caught up in Bulimia usually maintain normal or near normal body weight, some being overweight. The primary symptom is gorging rather than starving.

Let's look at the diagnostic criteria for Bulimia according to DSM III:

A. Recurrent episodes of binge eating (rapid consumption of large amount of food within a discrete time period--usually less than two hours).

B. At least three of the following:
   1. Consumption of hi-calorie, easily ingested food during a binge.
   2. Inconspicuous eating during a binge.
   3. Ending of such eating episodes by abdominal pain, sleep, social interruption, or self induced vomiting.
   4. Repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics.
   5. Frequent weight fluctuations greater than 10 lbs. due to alternating binges and fasts.

C. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily.
   (Note this difference from Anorexia. The Bulimic is aware of having an eating problem in contrast to the Anorectic's denial.

D. Depressed mood and self-deprecating thoughts after eating binges.

E. The bulimic episodes are not due to Anorexia Nervosa or any known physical disorder.
   (The victims of the two disorders can move from one diagnosis to another. That is, the anorectic can gain weight and meet the criteria for bulimia and an individual with Bulimia can lose weight and possibly meet criteria for anorexia. However, it is usually more common for the anorectic to move into Bulimia rather than vice-versa.

Note that contrary to popular belief, purging is not required for the diagnosis of bulimia (although it does occur in the majority of cases). Bulimia has only recently been recognized and defined. These criteria will no doubt be refined as therapists get more experienced. Other related disorders may also be identified as there certainly are people who fit neither category exactly yet have distinct food related problems. The relationship between Anorexia Nervosa and Bulimia remains a controversial issue. Historically, bulimia was viewed as a subtype of Anorexia Nervosa. Researchers discovered that approximately half of the anorectic population occasionally or regularly broke their fasts, ate more than they would normally allow themselves to and then vomited or used some other means of eliminating the calories. This group was said to have the symptom of bulimia within the context of anorexia nervosa. Later, the term bulimia was attached to a newly identified disorders, distinct from Anorexia Nervosa. Consequently, we confront a problem when reading the literature. When we run across the term Bulimia, or even articles entitled bulimia, we need to determine if we are in fact reading about a subtype of anorexia or if we are reading about the separate syndrome of bulimia Some of you are probably familiar with other terms such as bulimarexia, bulimia nervosa, etc. However, at this point, DSM III does not recognize these as distinct diagnostic categories.

To summarize, the basic differences between Anorexia and Bulimia are:

1) The anorectic compulsively starves, whereas the bulimic gorges.

2) The anorectic is always abnormally underweight, the bulimic is not. As mentioned before, the bulimic is usually normal or somewhat above normal in weight.

3) The bulimic is aware of having an eating problem whereas the anorectic denies it.

In practice, the counselor or therapist need not be extremely concerned about having a very precise differential diagnosis. What is critical is being clear as to whether the client has an eating disorder, understanding what is going on, and developing an effective treatment approach.

Selected Intake Interview Questions

An evaluation of patients with anorexia and/or bulimia involves a comprehensive examination of: 1) the pattern of eating prior to and after the onset of eating disorder; 2) symptoms frequently associated with the eating disorder; 3) level of social functioning and activity; and 4) medical and psychiatric history. In addition, in order to make an appropriate diagnosis, it is important to rule out any primary medical or psychiatric problems which involve symptoms similar to those found among patients with anorexia or bulimia.

When doing a diagnostic interview, here are some sample questions frequently asked that specifically relate to an eating disorder:

1. Do you have health concerns?
   Have you had a physical exam lately?
   Was the physician aware of a possible eating disorder?

2. Are you aware of any weight loss?
   How many pounds do you presently weigh?
   What is your ideal weight? (95% of high school aged women in the U.S. would like to weigh 5 pounds less).
   Were you ever overweight? What is your ideal weight range? highest weight? lowest weight?

3. Is your menstrual cycle regular? irregular? stopped?

4. Do you feel fat? To what degree?
   Are you afraid of becoming overweight?
   Are you afraid of not being able to stop eating?
   To what extent to you feel out of control?

5. Do you binge eat?
   Define what a binge means to you.
   ("Large amounts " of foods may mean different quantities for different people).
   Does binge eating interfere with your life? How? To what extent?
   Are you comfortable eating in front of people?

6. Do you ever induce vomiting after eating? How often?
   Do you ever chew and spit food out?
   Do you avoid certain foods?

7. Do you ever fast? How often? How long?

8. Do you ever use laxatives or diuretics to lose weight? How many are used? How often?

9. Do you exercise?
   What type of plan do you follow?
   How often do you exercise?

10. Do you think you eating pattern is normal or abnormal?

11. Do you find yourself thinking about food and calories much of the time? Why do you think that is?

12. Do you feel free to discuss your real thoughts and feelings with family and friends? What is your support system like? How do you handle conflict?

13. Have you ever been treated for an eating disorder?
    Have you ever stolen anything?
    Kleptomania (stealing for stealing's sake) is often a diagnosis associated with eating disorders).

This list of questions is not all inclusive. You may want to assess other areas by taking a family and social history, by checking out appetite and sleep disturbances, social withdrawal and other DSM III criteria for depression, and checking for symptoms of chemical addiction, plus addressing any other issues you would normally evaluate with your client.

Section III
Philosophy Statement

Our philosophical approach to treatment involves the clients beginning to become aware of and to take responsibility for their own eating behaviors. Three ideas are important in this approach to treatment:

1. The first of these ideas is that the recovery process must be two fold.

   a. In planning for recovery, the eating pattern of starving and bingeing needs to be changed. The objectives are:

      1. to restore adequate nutrition with the least restrictive approach,

      2. to allow the client to collaborate in all decision making to the extent she is capable,

      3. to contract for an acceptable weight range and the stabilization of weight within this range, and

      4. in the case of the anorectic, to set a limit at which you agree if the weight limit is transgressed, will result in hospitalization.

      These objectives are promoted by nutritional consultation, and by referral to self-help groups such as OA and bulimics anonymous. However, the major approaches to changing the eating patterns are hospitalization, individual therapy, family therapy, and group therapy.

   b. The second important area in planning for recovery is to deal with the underlying thoughts and feelings that are triggering the eating/starving behaviors. It is important to learn to cope in a positive, rational way with thoughts and feelings such as loneliness, anger and boredom, guilt, perfectionistic tendencies, all-or-nothing thinking, and issues of control common to individuals with eating disorders.

2. As a philosophical approach to treatment, in addition to looking at the recovery as a two-fold process, it must be remembered that recovery is long term, hard work.

3. And the third point in the philosophical approach to the treatment of eating disorders is that the recovery program must be individualized and have medical back-up. This will be discussed briefly in the section under Types of Therapy. The following are some other thoughts on our philosophical approach to treatment.

   a. There is no right way to recover.
   b. Motivation may be the most difficult task the therapist has in treatment.
   c. Permission for the client to take control of their own eating behaviors and allowing for the possibility of relapses must be built into the treatment plan. The treatment of relapse and how setting up reasonable expectations for change can help to remove the "triggers" to eating disorders will be dealt with more extensively after we discuss therapeutic interventions.

Related Problems

There are three other significant problems that frequently accompany an eating disorder that we need to concern ourselves with: depression, chemical dependency, and kleptomania.

Depression is, of course, one result of starvation. Therefore, in some cases, particularly anorexia, when adequate nutrition is reinstated and the individual reaches normal body weight, the depression disappears. However, there is a catch. If the normal body weight is achieved through coercive measures without adequate therapy to enable the individual to accept this higher weight, suicide is then a very real danger. Even with therapy, this is a critical period. The task of getting the anorectic to accept this higher body weight is a formidable one indeed.

With bulimia, guilt and depression are common after-effects of the bingeing and purging and again, as with any depression, we must always be alert to suicide potential.

While depression does not accompany all eating disorders, it is present in a great many cases and the latest thinking is that eating disorders, particularly bulimia, are part of a depressive syndrome. There is a great deal of research going on in this area and nothing can be stated with certitude yet we do know there is a high incidence of depression, eating disorders, chemical dependency and obesity in the family histories of those who binge/purge.

Antidepressants have been used with mixed results. However, there is a small but growing body of literature that indicates the efficacy of antidepressants. Our practice is to evaluate any existing depression and if appropriate, refer the student to one of the psychiatrists or physicians for a trial run of antidepressant medication. Our rationale for doing this is not to treat the eating disorder per se, but rather the depression itself. If an individual is indeed suffering from an endogeneous depression (endogeneous

meaning rising from within as opposed to reactive depression which is a response to the environment) then there is a good chance they will respond positively to the medication. However the choice of medications should be carefully made since increase in appetite is one of the side effects of certain antidepressants. We find that when the depression is alleviated, the individual naturally has more energy and inner resources at her disposal for dealing effectively with the eating problem. I compare it to trying to swim with a 20 pound rock hung around your neck. Get rid of the rock and it's a whole lot easier to keep your head above water.

Chemical dependency is present in many family histories and very frequently accompanies bulimia. Unfortunately in most chemical dependency treatment programs, the bulimia is not addressed-or individuals are told once they get their drinking under control the bulimia will disappear - which it usually does not. It may well be that the bulimia is the primary addiction with the chemicals being used as a substitute for eating or to assuage the guilt and depression associated with the binge/purge behaviors. In any case, both the chemical dependency and eating disorder must be directly addressed in treatment lest the individual retreat further into one or the other.

Kleptomania is another compulsive action which frequently accompanies binge behavior - whether it's in the context of anorexia or bulimia. Since victims of these disorders are by and large highly principled people, this is something that often doesn't occur to therapists or others to check out. Clients often are referred as a result of a court action related to stealing/bad checks.

Section IV
Types of Therapy

When assessing needs and planning therapeutic interventions, one of the first things you need to do after someone comes for help with an eating disorder is to receive some assurance that they are physiologically stable. There are many very serious side effects that can occur from laxative abuse and vomiting in particular, not to mention the effects of starvation. Probably the most common and potentially serious of these are dehydration and electrolyte imbalance. These are particularly insidious because they are not obvious to the casual observer yet can cause death. So it's critical to have the individual medically evaluated by a physician. The physician chosen should be one who is aware of the kinds of problems to be on the lookout for and who is willing and able to treat the patient in a warm, friendly manner and discuss her treatment openly. It is vital that the physician and therapist, along with dietitians or any other professionals involved work together as a team and be perceived as a team by the patient. Otherwise there is a strong likelihood that one will be played against the other.

You will also need to decide whether to treat the individual alone, with the family, in a group, or with some combination of these. Some specialists in the field maintain family therapy is essential in cases of Anorexia Nervosa--others dispute this as a necessity. Generally speaking, however, the anorectic is a more likely candidate for family therapy while the individual with bulimia tends to fare better in group. The second consideration is the client's age. The younger the client, the more appropriate family therapy is. In making this choice, the therapist must also assess the availability and motivation of family members to participate. The younger the client, the more behavioral, structured, and directive the intervention will need to be.

The third consideration in planning therapeutic interventions is severity of the disorder. Again in the case of the anorectic, the more severe the symptoms are, the more structured and restrictive the treatment, such as hospitalization, needs to be. The kinds of things we look at in determining how restrictive the treatment needs to be are: extent of weight loss, physical stability, the degree of cognitive distortion, the degree of social withdrawal and the extent of suicidal ideation. Outpatient therapy simply can't impose the necessary controls to counteract the effects of severe symptoms. (All eating disorders have cognitive disturbances, but the disturbances of the anorectic may be based on physiological and chemical changes that result in significant thinking impairment. Therefore, it may not be productive to treat the anorectic until the physiological basis of the disorder is controlled by inpatient hospitalization). Furthermore, at this point family members are not very invested in the psychological contributions to the disorder. But during and immediately following hospitalization, family therapy can be very effective. By this time the individual is well enough to make use of the therapy (that is, their thinking is not as distorted, depression is not as severe, etc.)

This state of affairs is not necessarily the case with the bulimic where severity of symptoms may not be a contraindication for family or individual therapy. Bulimia:

--doesn't result in the dramatic physical and cognitive deterioration noted in severe anorexia nervosa.

--in many cases, the more severe the bulimia, the greater the likelihood of success with family therapy, as the presence of severe bulimia is highly disruptive to the rest of the family and typically precipitates a crisis which provides motivation for all family members to participate in treatment.

--then the bulimic is typically referred to group therapy.

Since bulimia treatment programs are still in their infancy, it's too early yet for much in the way of outcome studies. The bulimia treatment programs that do appear to be successful thus far have 4 components in common: (1) education, (2) self monitoring or record keeping, (3) an emphasis on reducing the behavior (stimulus control and response prevention), and (4) cognitive restructuring (or changing thinking patterns).

Thinking patterns can be challenged by both the anorectic and the bulimic. Rational thinking is encouraged by raising the following kinds of questions with the client:

1) Is this really the thought you want to be thinking?

2) What do you know about yourself or your experiences that says this may not be true?

3) Is this thought helpful for your recovery?

Having the clients write down irrational thoughts gives the therapist a basis for assessing changes in thinking patterns, for helping the client develop rational coping thoughts, and for dealing with reality instead of fears.

Below is a comparison of bulimic thoughts and rational thoughts.

BULIMIC THOUGHTS	RATIONAL THOUGHTS
GO AHEAD AND EAT IT -- YOU CAN GO THROW IT UP.	I CAN EAT IT, BUT I CAN CHOOSE NOT TO THROW IT UP, TOO. JUST BECAUSE I MAKE ONE MISTAKE DOESN'T MEAN I HAVE TO PUNISH MYSELF MORE.
I KNOW THIS BINGE WILL BE MY LAST.	I WISH THIS COULD BE MY LAST, BUT I'LL PROBABLY BE TEMPTED AGAIN. I KNOW I CAN WORK ON HAVING LONGER TIMES BETWEEN BINGES, THOUGH.
ONE DISH OF ICE CREAM WON'T HURT ANYTHING.	IT WON'T HURT ANYTHING, BUT I MIGHT NOT LIKE MYSELF AS WELL AS IF I REMEMBER MY GOAL.
I DON'T FEEL LIKE I'M MAKING ANY PROGRESS -- AND IF I'M NOT MAKING ANY PROGRESS, WOULDN'T IT BE LOGICAL TO JUST QUIT?	I MIGHT BE MAKING JUST A TINY BIT OF PROGRESS IN SOME AREA. I NEED TO CONCENTRATE ON WHAT I'M FEELING GOOD (OR EVEN PRETTY GOOD) ABOUT.
I FEEL LIKE I'M ABOUT A HUNDRED POUNDS TOO FAT.	THAT'S HOW I FEEL, BUT I'M NOT REALLY. THERE ARE OTHER THINGS I'M FRUSTRATED WITH THAT MAKE ME UNHAPPY WITH MYSELF, OTHER THAN WEIGHT.
THIS EATING DISORDER IS NOT REAL, I CAN EAT ANY WAY I PLEASE.	IF IT'S NOT REAL, WHY AM I FOCUSING ON IT SO MUCH? IT IS CAUSING PROBLEMS FOR ME IN ADDITION TO THE ONE'S I ALREADY HAD.
JUST A LITTLE BIT IS OKAY -- I DON'T FEEL LIKE BINGEING.	WHY SET MYSELF UP OR "TEST MYSELF" WHEN I KNOW THE ONLY PERSON I'M HURTING IS ME. AM I REALLY HUNGRY, OR IS THERE SOMETHING ELSE I NEED TO LOOK AT?

You will find additional treatment guidelines for both anorexia nervosa and bulimia in your packets.

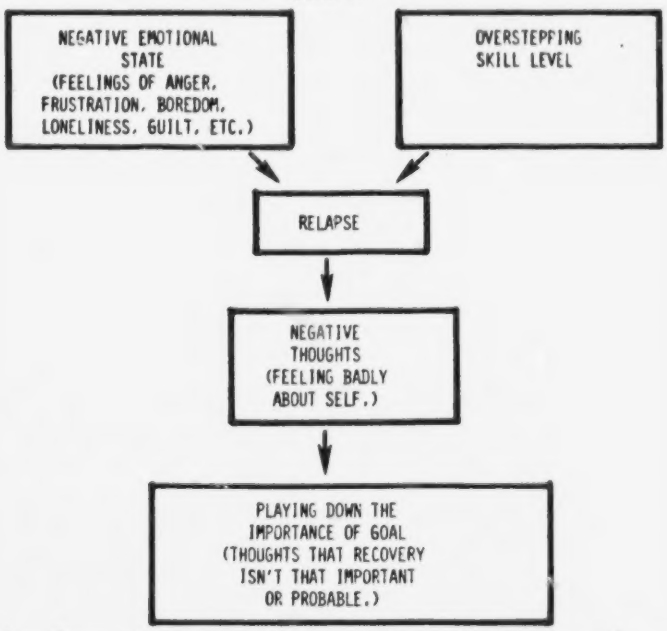
Section V
Relapse

Relapse is a common and frustrating pattern in the treatment process and one which both the counselor and client need to be prepared for. When an individual has abstained, for example, from bingeing and/or purging for a period of time, it can be extremely frustrating and demoralizing to experience a relapse into the old behaviors. When this happens, the tendency for the client is to slip into all-or-none thinking with thoughts such as "I'm a failure, I'll never be able to do this. Why try?" When this happens, it becomes a real challenge to keep the client engaged in treatment.

We've found the work of Allan Marlatt to be helpful in putting relapse behaviors into a different perspective. Marlatt views relapse as a part of the recovery process and as a means of developing new coping skills.

See table 1 below:

TABLE #1



Taken from: Neuman and Halvorson, Anorexia Nervosa and Bulimia, Van Nostrand Reinhold, 1983.

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Marlatt defines two factors that play an important role in precipitating a relapse. One is a negative emotional state which the person previously coped with by engaging in the behavior they are now trying to eliminate, such as bingeing. Feelings such as anger, loneliness, boredom are examples of common triggers.

The second precipitating factor is overstepping one's skill level. As clients work to develop new coping skills, they will more than likely encounter situations which they are not yet able to handle successfully. For instance, a person with Anorexia Nervosa may be doing well in terms of eating enough each day and reversing the weight loss. But if a friend comes up and says "Hey, it looks like you're putting on a few pounds," she is likely to be bombarded with anorexic thoughts. If she has not yet sufficiently developed the ability to counter these thoughts, a relapse is likely to occur. Often the relapse is a combination of both factors.

Once relapse occurs, the individual develops extremely negative thoughts about herself. At this stage she does not give herself any credit for the progress that has been made but rather, focuses on the relapse as proof of her unworthiness and her inability to recover.

From here she proceeds to the next destructive thought stage--that is, playing down the importance of recovery--contending that the behavior is not that bad and recovery is not important or probable.

If we can teach clients to view relapse in a different way though, it can be helpful, rather than detrimental to the long term recovery process. Relapse must be reinterpreted as part of positive skill development, and preferably cognitive restructuring should begin early in treatment to prepare the client for relapse. An analogy might be learning to ride a bike--it requires a few falls in order to learn how to maintain one's balance. Likewise, relapse can be opportunity to learn more about what leads one into difficulty and what kinds of skill building are necessary for eventual recovery.